SURGERY FOR THE TREATMENT OF MORBID OBESITY - Page 1 of 3 FOLLOW-UP REPORTS

Indiana State Department of Health State Form 53322 (6-07)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:
1 Print firmly and neatly. 3 Fill in circles like this: • 4 Print capital letters only 1 Print firmly and neatly. 5 Please complete all items on form.
2 Only use pens with blue or Not like trils.
,
Section 1. Patient Information
Change of patient address and/or phone numbe
Last Name
First Name MI Phone Number
That Name Mile Friorie Number
Number & Street Address
City State ZIP Code
County Date of Birth (mm/dd/yyyy) Age (years)
Sex: Race (select all that apply):
O Male O Female O Unknown O Asian O White O Black or African American O Other/Multiracial
Ethnicity: O American Indian or Alaska Native O Unknown
O Hispanic or Latino O Not Hispanic or Latino O Unknown O Native Hawaiian or Other Pacific Islander
Section 2. Surgery Follow-up Information
Select the follow-up interval for this report:
O 30 days O 60 days O 90 days O 1 year O 2 years O 3 years O 4 years O 5 years
Initial Surgical Procedure(s) Performed:
CPT Code CPT Code CPT Code CPT Code
Follow-up Measurements:
BMI: Waist Circumference:
Inches
Comorbidities:
ICD-9-CM code ICD-9-CM code ICD-9-CM code ICD-9-CM code
Complications and Side Effects:
Death? O Yes O No If Yes, cause of death (ICD-10 code) Date of death (mm/dd/yyyy)
Complications of initial oursers? O Voc. O No.
Complications of initial surgery? O Yes O No If Yes, complication(s):
ICD-9-CM code Date of complication onset ICD-9-CM code Date of complication onset

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Section 2. Surgery Follow-up Information (Continued)

Complications (continued): Hospitalization for complication(s)? O Yes O No If Yes, date of hospitalization (mm/dd/yyyy) Status at time of discharge (selet only one): O Against Medical Advice O Nursing Facility O Routine/Self-care O Other Hospital O Home Health Care O Other Institution, type: | Rehabilitation: Hospice: O Home O Inpatient O Inpatient O Outpatient O Skilled Nursing Facility O Expired If Yes, date of surgery (mm/dd/yyyy): Surgery for complication(s)? O Yes O No Procedure(s) performed: Other invasive treatment required? O Yes If Yes, type and description: Side effects of initial surgery? O Yes O No If Yes, side effect(s): ICD-9-CM Code Date of side effect onset Hospitalization for side effect(s)? O Yes O No Length of stay Name of Facility in days Status at time of discharge (select only one): O Against Medical Advice O Nursing Facility O Routine/Self-care O Other Hospital O Home Health Care O Other Institution, type: Rehabilitation: Hospice: O Home O Inpatient O Outpatient O Inpatient O Skilled Nursing Facility O Expired

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Section 2. Surgery Follow-up Information (Continued) If Yes, date of surgery (mm/dd/yyyy): Surgery for side effect(s)? O Yes O No Procedure(s) performed: Other invasive treatment required? O Yes O No If Yes, type and description Surgeon's Indiana License Number Name of Surgeon Telephone Number Section 3. Additional Information and Comments Comments: First Name of Person Completing Form Last Name of Person Completing Form Date Form Completed (mm/dd/yyyy)